STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DINI DDIG	00	COMPLETED
		155386	A. BUILDING B. WING		05/12/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	t		LIBERTY ST	
ΙΔΗΡΕΙ	S OF DEKALB			ER, IN46721	
				-11, 114-0721	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	mat.		F0000	The Lourses of DoKalb wish	an to
	This visit was	for a Recertification	F0000	The Laurels of DeKalb wish have this submitted plan of	es to
	and State Licensure Survey. This			correction stand as its allega	ation
	visit included	the Investigation of		of compliance. The date of	
	Complaint IN	•		alleged compliance is	
		00007072.		6/11/11.Preparation and/or	
				execution of this plan of correction does not constitute.	te
	Complaint IN	00089892-		admission to, nor agreemen	I
	Substantiated.	No deficiencies		either the existence of or the	• • • • • • • • • • • • • • • • • • •
	related to the a	allegations are cited.		scope and severity of any of	f the
		arreguerons are ereca.		cited deficiencies, or conclu	
				set forth in the statement of	
	Survey dates(s	s): May 9, 10, 11, &		deficiencies. This plan is prepared and/or executed to	,
	12, 2011.			ensure continuing compliance	• • • • • • • • • • • • • • • • • • •
				with regulatory requirements	
	Facility number	er: 000574			
	_				
	Provider numb				
	AIM number:	100266430			
	Survey team:				
	Sue Brooker, l	RD -TC			
	Christine Fodr				
	Sheryl Roth, F				
	Angie Strass, 1	RN			
	(5/10, 5/11, 5/	12, 2011)			
	Rick Blain, Ri	*	1		
	(5/11, 5/12, 20				
	(3/11, 3/12, 20	,11)			
	Census bed type:				
	SNF/NF: 90				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M0R511

Facility ID:

(X6) DATE

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		A. BUILDING B. WING	00	ì í	ESURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		STR 520	EET ADDRESS, CITY, STATE OW LIBERTY ST TLER, IN46721	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	TO THE APPROPRIATE	(X5) COMPLETION DATE
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN REGULATORY OR Total: 90 Census payor Medicare: 9 Medicaid: 54 Other: 27 Total: 90 Sample: 19 These deficient findings cited 410 IAC 16.2.	type: cies reflect state in accordance with	ID PREFI	PROVIDER'S PLAN IX (EACH CORRECTIVE A' CROSS-REFERENCED 1	CTION SHOULD BE TO THE APPROPRIATE	COMPLETION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155386	B. WINC			05/12/2	011
			F		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				IBERTY ST		
LAURELS	S OF DEKALB				R, IN46721		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Ι ΄	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0272 SS=D		onduct initially and prehensive, accurate,					
00-0		oducible assessment of					
	each resident's functional capacity.						
	Δ facility must mak	ke a comprehensive					
		esident's needs, using the					
	'	ne State. The assessment					
	must include at lea						
	Customary routine	demographic information;					
	Cognitive patterns						
	Communication;						
	Vision;						
	Mood and behavion Psychosocial well-						
		ng and structural problems;					
	Continence;						
	_	and health conditions;					
	Dental and nutritio	nal status;					
	Skin conditions; Activity pursuit;						
	Medications;						
	Special treatments						
	Discharge potentia						
		summary information tional assessment					
		the resident assessment					
	protocols; and						
		participation in assessment.	ļ				
	Based on reco	rd review and	F02	272	Resident #4's eye infection h resolved. No negative outco		06/11/2011
		facility failed to			resulted from this observation		
	ensure docume	entation of			Resident's medical records h		
		eye infection/itching			been reviewed. Any resident receiving eye treatments will		
	for 1 of 1 resid	lents reviewed with			assessed and documentation		
eye infection	eye infections	in a sample of 19			provided in the clinical record.Licensed nurses will be	e l	
	residents revie	ewed for assessments.			in-serviced on documentation of assessments on 5/26/11. All		
	(Resident #4)						
					telephone orders and 24 hou	I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M0R511 Facility ID:

000574

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/12/2	ETED	
	PROVIDER OR SUPPLIER		B. WING OS/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CR	ed by e for and ved for	(X5) COMPLETION DATE
	included, but v post traumatic (PTSD), deliri insufficiency, hypertrophy (I cerebrovascula	vere not limited to, stress disorder um, renal benign prostatic			for 3 times a week for 4 weeks, then weekly for 4 weeks, the monthly thereafter until resolved. Unit Manager/Desi will report any abnormal find to the Director of Nursing. To Director of Nursing will report these findings to the Quality Assurance Committee for the next 3 months (Addendum: quarterly thereafter for 1 years).	ks, gnee lings The rt e and	
	4/15/11 and sign Practitioner, in was seen for a visit. The note resident had a complaints incomew order was ointment to the two weeks. The documentation	gned by the Nurse adicated Resident #4 thirty day progress e further indicated the few minor vague cluding itchy eyes. A listed for an e eyes every shift for	The Quality Assurance Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will review the progress of findings and offer input as necessary to the Quality Assurance Committee.The Administrator is responsible for continued compliance with the regulation.			ed is ctor for	
	regarding the of A "Interdiscip!	eyes of the resident. linary Care Plan," indicated Resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/12/20	ETED	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/12/2	
NAME OF I	PROVIDER OR SUPPLIE	2			LIBERTY ST		
LAUREL	S OF DEKALB			1	R, IN46721		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		lem with dry eyes					
	with a goal of	• •					
		dry eyes. The only					
	intervention li	• •					
	ointment as or						
	An untitled as	sessment form, dated					
	4/19/11, and c	ompleted by Resident					
		r, indicated the					
	resident was b	eing seen for lost					
	eyeglasses and	d eyes that itched and					
	hurt. There w	as no documentation					
	in the nurses'	notes regarding the					
		the resident's eyes or					
	any symptoms	s that he was having					
	in this area.						
	_	1, Medication Record					
		4, listed a new					
	antibiotic eye	ointment order, dated					
		applied at bedtime					
	, , ,	r ten days. The					
	resident was a	~					
	1	ointment three times					
	1 '	4/17/11 and artificial					
		es a day starting					
	3/28/11.						
	A "Interdiscip	linary Care Plan,"					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SUF COMPLETI	
ANDILAN	or connection	155386	A. BUI			05/12/201 ⁻	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				LIBERTY ST		
LAUREL	S OF DEKALB			BUTLE	R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION DATE
		indicated Resident					
	·	em with eye drainage					
	with a goal of	no drainage or no					
	_	ptoms of infection.					
	The only inter	-					
	i -	nedication as ordered.					
	_						
	There was no	further					
	documentation	n in Resident #4's					
	record indicati	ng the facility had					
	re-assessed the	e eyes for continuing					
	signs and sym	ptoms of itching or					
	infection while	e being treated with					
	the antibiotic of	ointment and artificial					
	tears. There w	as no documentation					
	that Resident #	44 had been assessed					
	for resolution	of the infection once					
	the antibiotic of	ointment had been					
	discontinued of	on 4/29/11.					
	On 5/12/11 at	-					
		rsing provided the					
		n policy, dated 3/11,					
		the policy was the					
	· ·	used by the facility.					
		luded, but was not					
		Documentation					
	should not be '	block' or 'shift'					
	entries. Entrie	es need to be made					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386		LDING	NSTRUCTION 00	i .	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COD LIBERTY ST R, IN46721	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	when document that everything guest's conditi treatment is rephysician visit documented in notes" LPN #20 was 5/11/11 at 2:00 interview, LPN a resident is ploor medication charting would routinely for the medication and	interviewed on 0 p.m. During the N #20 indicated when aced on an antibiotic for an eye infection, d be completed the duration of the d would include eye redness, drainage,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155386	B. WING			05/12/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	r E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE	
F0280 SS=A	incompetent or oth incapacitated under participate in plant changes in care at						
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.						
	update the nutrof 19 residents	facility failed to rition care plan for 2 (Resident #4 and reviewed with care ple of 19.	reflect the Resid weight goal by to Dietary Manage outcome results observation. Residents' Nutron have been revisible of each residen Manager/Design		plan was updated on 5/12/11 reflect the Resident's current weight goal by the Certified Dietary Manager. No negative outcome resulted from this observation. Resident #47 no longer resides at the facility. Residents' Nutritional care place been reviewed and have been updated to reflect the sof each resident. The Dietary Manager/Designee will review Resident Nutritional care place.	to ve All lans ve tatus w all	06/11/2011
	reviewed on 57. The record indiagnoses inclinated to, position disorder (PTS)	he record indicated Resident #4's agnoses included, but were not mited to, post traumatic stress sorder (PTSD), delirium, renal sufficiency, benign prostatic			monthly for 2 months. All Nutritional care plans will be updated accordingly. All find will be reported to the Administrator monthly and to Quality Assurance Committee the next 2 months (Addenum and then quarterly thereafter year). The Quality Assurance	the e for n: for 1	

000574

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155386	A. BUI		00	05/12/2	
		100000	B. WIN		DDDEGG CITY CTATE ZID CODE	00/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST		
LAUREL	S OF DEKALB			1	R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG		·		IAG	Committee will monitor any		DATE
	hypertrophy (I				negative trends until resolve	d and	
	cerebrovascula	ar accident (CVA).			initiate additional education	م: ام	
	11/5/10 with a indicated Residual	'Plan of Care," dated goal date of 7/21/11, dent #4 had a goal to reight within 5% of		initiate additional education and/or monitoring as the need is identified. The Medical Director will review the progress of findings and offer input as necessary to the Quality Assurance Committee.The Administrator is responsible for continue compliance with the regulation.			
	The "Nutrition	al Data sheet, dated					
	3/24/11 by the	Certified Dietary					
	Manager, indi	cated Resident #4					
	weighed 139.4						
		F					
	The "Progress	Notes," dated					
	_	Registered Dietitian,					
	•	dent #4 weighed 139					
	pounds.	delit ii i weighed 139					
	pounds.						
	indicated the f weight was ind weights were	Notes," dated Registered Dietitian, acility's admission correct. Hospital 114 - 119 pounds. er indicated the					
	weight for Apr	ril to be 111 pounds.					
	The "Progress 4/20/11 by the	Notes," dated Registered Dietitian,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 00	COM	TE SURVEY SPLETED 2/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO LIBERTY ST R, IN46721	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	indicated Resi 116.4 pounds.	dent #4 weighed					
	was interviewed a.m. During the DON indicated updated the ca	of Nursing (DON) ed on 5/12/11 at 9:10 he interview, the d the facility had now re plan to show the of 116 pounds.					
	Resident #47's but were not li	/2011 at 8:10 a.m. diagnoses included mited to; lementia, and high					
	200 ml per ho	order for Jevity 1.5 at ur every 4 hours as a eived on 4/14/2011.					
	was received t	n physician's order o begin Osmolyte igh protein when					
	The Medication	on Administration					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155386	- 1	LDING		05/12/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				LIBERTY ST	
LAUREL	S OF DEKALB			BUTLE	R, IN46721	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	record for 5/20					J.M.D
		nad begun receiving				
		calorie, high protein				
	on 5/8/2011.					
	011 07 07 2011.					
	A review of ca	re plans produced the				
	following; a ca					
	4/14/2011 and	updated 5/5/2011,				
	titled nutrition	: at risk for weight				
	changes indica	ated to begin				
	Osmolyte whe	n it became available.				
	A second care	plan, dated				
	4/14/2011, title	ed nutrition: risk of				
	dehydration in	dicated to provide				
	Jevity as order	ed. A third care plan,				
	dated 4/14/201	1, titled potential for				
	gastrointestina	1 distress indicated				
	Jevity was to b	be given per tube as				
	ordered. A fou	rth care plan, dated				
	4/14/2011, title	ed potential for skin				
	breakdown inc	licated provide Jevity				
	as ordered per	tube. A fifth care				
	plan, dated 4/1	4/2011, titled skin:				
	pressure area t	o buttocks indicated				
	see nutrition ca	are plan for diet				
	change.					
	In an interview	v on 5/12/2011 at				
	10:45 a.m., the	e Director of Nursing				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL			
AND PLAN	OF CORRECTION	155386	A. BUILI	DING	00	05/12/2	
		100000	B. WING	OED FEET :	DDDEGG GWW GWW GW	00/12/2	O 1 1
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LAURELS	S OF DEKALB				R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	indicated there	was no policy					
	regarding care	plan updates. She					
		dicated care plans					
	should be kept	•					
	should be hep.						
	In an interview	y on 5/12/2011 at					
		Minimum Data Set					
	_	dicated although					
		•					
	_	olicy regarding care					
		care plans were to be					
	updated with n	new orders.					
	3.1-35(d)(2)(B						
F0282		ded or arranged by the					
SS=D		ovided by qualified persons n each resident's written					
	plan of care.	reach resident's written					
		rvation, interview	F02	82	Resident # 47 no longer resident		06/11/2011
		iew, the facility			in the facility.Resident # 10's comprehensive care plan has		
		e positioning devices			been reviewed and reflects the		
		as ordered by the			physicians' order to monitor t		
	physician for 2	•			positioning device every 30 minutes and release every 2		
					hours. No negative outcome		
		lap trays in a total			resulted from this observation	n.All	
	_	(Resident #10, and			Residents using lap trays have been identified. The physicial		
	Resident #47).				orders have been reviewed a		
					the comprehensive care plan	1	
					updated to reflect the status	of	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	M0R511	Facility II	D: 000574 If continuation sh	neet Pac	ge 12 of 27

M0R511 Facility ID:

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED 05/12/2011
		155386	B. WIN			05/12/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
LALIDEL	S OF DEKALB			1	LIBERTY ST R, IN46721	
					N, 1140721	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	Findings inclu				each resident. The licensed	
	Tilldings illeid	de.			nurses will be in-serviced on	
					5/26/11 on monitoring every	
	1. Resident #1	0's record was			minutes and releasing lap tra every 2 hours for care.The	iys
	reviewed on 5/	/9/2011 at 12:05 p.m.			licensed nurses will monitor a	and
	Resident #10's	diagnoses included			ensure that all residents usin	l l
		mited to; dementia,			trays will be checked every 3	
		d Parkinson's disease.			minutes and released every a hours for care. The Unit	2
	depression, and	d I dikinson s disease.			Managers/Designee will mon	iitor
	T 4.	1 4.			compliance 3 times a week for	
		s observation on			weeks, then weekly times 4	
		ween 8:30 a.m. and			weeks, and then monthly thereafter.The Director of Nu	rsing
	11:30 a.m., Re	esident #10 was			will report the findings to the	Tomig
	observed in hi	is wheelchair with a			Quality Assurance Committee	e
	lap tray on, in	his room in front of			monthly for 3 months (Addendum: and then quarte	orly
		between 8:30 a.m.			therafter for 1 year.) The Qu	
		at ball toss in the			Assurance Committee will	,
	·	etween 9:15 a.m. and			monitor any negative trends	
	_				resolved and initiate addition education and/or monitoring	
		ng in his room			the need is identified. The	
		a.m. and 11:00 a.m.,			Medical Director will revew th	
	and sitting in t	he hallway between			progress of findings any offer input as necessary.The	
	11:00 a.m. and	l 11:30 a.m. Resident			Administrator is responsible	for
	#10 was not to	oileted nor his lap tray			continued compliance with th	ie
	released during	g this time.			regulation.	
	•					
	A nhysician's a	order, dated 5/5/2011,				
		dent #10 was to have				
		ray and be monitored				
		tes and released				
	every 2 hours.					

000574

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MU AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE	
ANDILAN	or connection	155386	A. BUI		00	05/12/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	LIBERTY ST		
LAUREL	S OF DEKALB			BUTLE	R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
-		v on 5/12/2011 at		-			
	9:10 a.m., the	Director of Nursing					
	indicated their	restraint policy was					
	not specific for	r releasing restraint,					
	but Lippincott	's manual was					
	utilized as a pa	art of their policy.					
		pincott's manual					
	1 0	in the facility was					
	*	e Director of Nursing					
		at 9:10 a.m. Page					
		under guidelines, e.					
		are restrained should					
	·	tercised, toileted and					
		rin redness every 2					
	hours.						
	2 D: 1 #/	171					
		47's record was /2011 at 8:10 a.m.					
		diagnoses included					
	but were not li	lementia, and high					
	blood pressure						
	olood pressure	·•					
	In a continuou	s observation on					
		ween 12:45 p.m. and					
	3:15 p.m.; Res	-					
	•	g in his wheel chair					
		on, between 12:45					
		•					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X		
		155386	A. BUILDING B. WING		COMPLETED 05/12/2011	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
	S OF DEKALB			LIBERTY ST R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	11, 1114-0721	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	l ^	p.m. in the hall				
	l	p.m. and 2:00 p.m.				
		zzle in the activity				
		2 p.m. and 3:15 p.m.				
		sident #47 was not				
	toileted nor his	s lap tray released.				
	A physician's of	order, dated 5/2/2011,				
	indicated use v	wheel chair tray when				
	up in wheel ch	nair monitor every 30				
	minutes and re	elease every 2 hours.				
	In an interviev	v on 5/12/2011 at				
	9:10 a.m., the	Director of Nursing				
	indicated the r	estraint policy used				
	by the facility	was not specific for				
	release, howev	er Lippincott's				
	manual was ut	ilized as a part of				
	their policy.					
	3.1-35(g)(2)					
70045	A	omahla ta aama ay ta 2000				
F0312 SS=D		unable to carry out activities ives the necessary services				
JO-D	to maintain good r	nutrition, grooming, and				
	personal and oral	hygiene. rvation, interview	F0312	Resident # 47 no longer resi	des 06/11/2011	
	Dascu oli oose	i valion, interview	10312	in the facility.Resident # 10 h		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155386	B. WING			05/12/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			520 W I	LIBERTY ST		
	S OF DEKALB				R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		··		IAG	no negative outcome resultir	na	DAIL
		iew, the facility			from this observation.All	9	
		e toileting per plan of			dependent Residents have b		
	care for 2 of 6	residents reviewed			identified. All nursing staff w in-serviced on 5/26/11 on toi		
	for toileting in	a sample of 19			dependent residents as	eurig	
	(Resident #10,	and Resident #47).			documented per plan of care		
					nursing staff will monitor and ensure that all dependent		
	Findings inclu	de:			residents are toileted per pla care.The Unit	n of	
	1 Resident #1	0's record was			Managers/Designee will mor compliance 3 times a week f		
		/9/2011 at 12:05 p.m.			weeks, then weekly times 4	01 4	
		•			weeks, and then monthly		
		diagnoses included			thereafter. The Director of Nu	-	
		mited to; dementia,			will report the findings to the Quality Assurance Committe		
	depression, an	d Parkinson's disease.			monthly for 3 months (Addendum: and then quarte		
	In a continuou	s observation on			thereafter for 1 year.) The C Assurance Committee will	-	
	5/10/2011 bety	ween 8:30 a.m. and			monitor any negative trends	until	
	 11:30 a m Re	esident #10 was			resolved and initiate addition	ıal	
	· ·	is wheelchair with a			education and/or monitoring	as	
		his room in front of			the need is identified. The Medical Director will revew the	ne	
		between 8:30 a.m.			progress of findings any offe		
					input as necessary.The	f	
	· ·	at ball toss in the			Administrator is responsible continued compliance with the		
		etween 9:15 a.m. and			regulation.		
	9:30 a.m., sitti	ng in his room					
	between 9:30	a.m. and 11:00 a.m.,					
	and sitting in t	he hallway between					
	_	l 11:30 a.m. Resident					
		oileted during this					
	time. Resident						
	observed to ha	we been toileted at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		A. BUI	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 2/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP C LIBERTY ST R, IN46721		•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	· ·	elothing was dry and served to have been					
	1:25 p.m., LPN Resident #10 v	v on 5/11/2011 at N #4 indicated was to be toileted er meals and when					
	9:10 a.m., the indicated Lipp	on 5/12/2011 at Director of Nursing incott's manual was art of their policy.					
	pages utilized provided by th on 5/12/2011 a indicated unde Residents who be released, ex	pincott's manual in the facility was e Director of Nursing at 9:10 a.m. Page 194 or guidelines, e. o are restrained should dercised, toileted and in redness every 2					
	reviewed 5/10	17's record was /2011 at 8:10 a.m. diagnoses included mited to;					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386			(X2) M A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 05/12/2	ETED
	PROVIDER OR SUPPLIER	!		520 W L	LIBERTY ST R, IN46721		
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEPICIENCY)	ΓE	(X5) COMPLETION DATE
IAU		dementia, and high		IAU			DATE
	In a continuou 5/10/2011 bet 3:15 p.m.; Resobserved sittin with a lap tray p.m. and 1:45 between 1:45 enjoying a purarea, between in the hall. Retoileted nor hi 3:15 p.m. CN to take Reside toileting. He whave been incompared between incompared to the have wet cloth. A care plan, dincontinence in frequently. In an interview 1:25 p.m., LP: Resident #47	as observation on ween 12:45 p.m. and sident #47 was ing in his wheel chair on, between 12:45 p.m. in the hall, p.m. and 2:00 p.m. in the activity 2 p.m. and 3:15 p.m. sident #47 was not is lap tray released. At A #10 was observed in the activity as not observed to continent nor did he in at that time. In atted 4/14/2011, titled indicated to toilet was to be toileted was to be toileted er meals and when					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRU				X3) DATE SURVEY COMPLETED			
		155386	A. BUIL B. WING			05/12/20	
	PROVIDER OR SUPPLIER S OF DEKALB			STREET A	.ddress, city, state, zip code LIBERTY ST R, IN46721		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
F0406 SS=D	9:10 a.m., the indicated Lipp utilized as a para 3.1-38(a)(3)(A state of the specialized rehabut not limited to, para services for mentar retardation, are recomprehensive plaprovide the require required services for accordance with § a provider of special services. Based on obset and record reverse failed to follow recommendation psychiatric his was obtained for reviewed for special services.	bilitative services such as, ohysical therapy, pathology, occupational al health rehabilitative I illness and mental quired in the resident's an of care, the facility must ed services; or obtain the from an outside resource (in 483.75(h) of this part) from alized rehabilitative rvation, interview iew, the facility v-up on a PASAAR	F0	406	Resident #4 was referred to psychiatric services on 5/12/No negative outcomes were identified during this observation. All Resident's PASARR have been reviewe Social Service Director/Designad any recommendations have been addressed. The Social Service Director/Designee wirefer Residents to specialized services as recommended in PASARR. The Social Service Director/Designee will monitor regulation for compliance monor of months and will report as	d by gnee ave iil d the or the	06/11/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386	A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF I	NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		A. BUII	G STREET A 520 W L	ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST R, IN46721 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) abnormal findings to the Administrator. The Administ will report these findings to t Quality Assurance Committee the next 3 months (Addenum: and then quarter	O5/12/20	
	#4 was mental less intensive a diagnoses includisorder, anxietraumatic stresservices to be facility includereview, psychimedication medication medical him for psychic could be looked depression. Howas involved a local hospital) note of this was a "Brief Interestatus (BIMS)	ly ill but required services. The uded depression ety disorder and post as disorder. The provided by the ed yearly resident eatric evaluation, onitoring, medication, and other. Other [It is unknown if the hospital) is treating eatric issues. "This ed into for help with the indicated to me he with the (name of for treatment but no as in chart"] view for Mental 1," dated 3/29/11, dent #4 scored a 10			thereafter for 1 year). The Cassurance Committee will monitor any negative trends resolved and initiate addition education and/or monitoring the need is identified. The Medical Director will review progress of findings and offeinput as necessary to the Quassurance Committee. The Administrator is responsible continued compliance with the regulation.	until nal as the er uality	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
ANDILAN	or correction	155386		LDING	00	COMPLETED 05/12/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				LIBERTY ST		
LAUREL	S OF DEKALB			BUTLE	R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	I	X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E COMPI	LETION TE
		rogress Notes," dated					
		a.m., indicated					
	Resident #4 ha						
	medication.						
	The nurses "Pi	rogress Notes," dated					
		p.m., indicated					
		as alert and oriented					
	to self/room ar	nd surroundings. The					
	note further in	dicated the resident					
	was unable to	recall the nurse's					
	name after five	e minutes.					
	The Social Ser	vice Director was					
	interviewed or	n 5/10/11 at 2:45 p.m.					
	During the into	erview, the Social					
	Services Direc	etor indicated she had					
	never followed	d up on the admission					
	PASAAR reco	mmendations before					
	today. She fur	ther indicated the					
	resident will n	ever accept this and					
	indicated he ha	as been depressed his					
	whole life.						
		D					
		Documentation					
		d 3/26/11, indicated					
		ates that he is a					
		ryone and has made					
	statements of o	death and how he					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386			(X2) MULTIF A. BUILDING	NSTRUCTION 00	(X3) DATE S COMPL 05/12/2	ETED
		155386	B. WING		05/12/2	011
NAME OF I	PROVIDER OR SUPPLIER		I	DDRESS, CITY, STATE, ZIP CODE IBERTY ST		
LAUREL	S OF DEKALB			R, IN46721		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI TA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	rE	COMPLETION DATE
	wishes he was	dead. A second				
	behavior recor	d indicated the				
	resident remov	es his personal				
	alarms and tra	nsfers himself.				
		1:10 p.m., Resident				
		ed sitting up in his				
		the lounge near the				
		. He was overhead				
	_	ne had come up to ne saw a psychiatrist,				
		me why. He further				
		anted to send him to				
	the third floor					
	someone, told					
		h what he said.				
		en a lot of death,				
	sometimes I ju	st want to go to sleep				
	and not wake	up," An unidentified				
	staff member v	was attempting to				
		sident when she told				
	1	vanted to make sure				
		e then stated, "Well if				
	I was, I would 	n't say those things."				
	2 1 22(2)					
	3.1-23(a)					

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING O CTUDING			
		155386	B. WING			05/12/20	011
	PROVIDER OR SUPPLIER		52	0 W LIE	DRESS, CITY, STATE, ZIP CODE BERTY ST IN46721		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F0514 SS=D	each resident in ac professional stand complete; accurate accessible; and sy The clinical record information to identhe resident's asseand services provipreadmission screstate; and progress Based on recordinterview, the ensure physician dictar available in the of 19 residents progress notes residents. (Refacility also fail doctor for 1 of for ophthalmol signed a note as	rd review and facility failed to an progress notes and ated notes were e clinical record for 1	F0514		Resident #4's physician progrotes were obtained and place in the clinical record. No negoutcome resulted from this observation. All clinical record have been reviewed to ensur progress notes are present. The residents will have progress in the clinical record after being seen by a physician. The Medical Director has been in-serviced this regulation on 5/24/11. The Medical Director will in-service the necessary attending physicians on this regulation 6/11/11. The physician will communicate with the facility each resident and the date in which they were seen. Medical Records will review the reside list provided by the physician ensure progress notes are	sed ative s e all All notes ng lical I on ne e by on	06/11/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID:

M0R511

000574

If continuation sheet

Page 23 of 27

AND PLAN OF CORREC	TION	IDENTIFICATION NUMBER: 155386	A. BUILDING	00	COMPLETED
		100000	1		05/12/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/12/2011
NAME OF PROVIDER C	R SUPPLIER			LIBERTY ST	
LAURELS OF DEF				R, IN46721	
			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE
PREFIX REGU Findin 1 Res review The re diagnor limited disord insuffi hypert cerebre A "Phy 4/15/1 Practit was se visit and dictate to "See for 4/1 A nurs 4/19/1 Reside doctor new or	ident #4 yed on 5 cord incoses included to, pose	ratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) de: 's record was /9/11 at 2:00 p.m. licated Resident #4's uded, but were not t traumatic stress D), delirium, renal benign prostatic BPH) and ar accident (CVA). Progress Note," dated gned by the Nurse adicated Resident #4 thirty day progress a full note was note further indicated ." No dictated note as located in the chart. Degress Notes," dated 45 a.m., indicated as seen by the eye ote further indicated a serceived and aring review of the	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	completion DATE linical limes ector lings Inths ly lality until lal las las lee r for
in the		gress Note was noted			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		DING 00		COMPLETED	
		155386		B. WING			05/12/2011	
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	_	ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG				TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	DATE	
	S OF DEKALB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL							
		th the DON, she						

l i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 05/12/2011	
		155386	B. WIN					
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE	
-	indicated she had made a call out to			-				
	the office to go	et a copy of the						
	progress note from the eye doctor.							
	The Director of Nursing was							
	interviewed on 5/11/11 at 1:00							
	1 •	s unaware of why the						
	eye doctor's note was not in the							
	resident's chart. She further							
	indicated the doctor's office had							
	just faxed over							
	assessment from the visit. The							
	DON provided the faxed copy of							
	the eye doctor's visit, dated 4/19/11.							
		The fax confirmation indicated the						
	1 -	ed the note on 5/11/11						
	at 10:32 (no a.m. or p.m. listed).							
	The Medical Director was							
	interviewed on 5/12/11 at 11:18 a.m. He indicated he was unaware							
	of why the eye	e doctor's visit note						
	was not in the	resident's chart. He						
	further indicat	ed, the eye doctor						
	usually has a f	form that he						
	completes whi	ch stays in the						
	resident's char	t.						
	3.1-50(a)(1) 3.1-50(a)(3)							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386	A. BUILDING B. WING	00	COMP 05/12/2	LETED	
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	3.1-50(a)(4) 3.1-50(e)(5)						